FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: UTAH
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) Utah Children's Health Insurance Program

SCHIP Program Type ____ Medicaid SCHIP Expansion Only
__X__ Separate SCHIP Program Only
_____ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date December 29, 2000

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program=s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ›NC: for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility N/C

2. Enrollment process N/C

3. Presumptive eligibility N/C

4. Continuous eligibility N/C

5. Outreach/marketing campaigns:

Throughout FFY 1999, a statewide media campaign was used to reach the large populations of CHIP-eligible children and, as a result, the program met all enrollment projections. However, despite this success, Utah felt that the broad based approach had saturated the market and during FFY 2000, turned its focus to increasing the level of targeted outreach. While still maintaining a statewide message and awareness of CHIP, Utah is now concentrating on identifying those segments of the population that may have been missed by the broad outreach approach.

6. Eligibility determination process N/C

7. Eligibility redetermination process:

Utah redesigned its CHIP renewal forms and established new renewal procedures in order to simplify and streamline the renewal process for the CHIP clients and the eligibility staff. These changes were implemented July 2000. The new form, sent to CHIP clients at the end of the twelve month continuous enrollment period, includes the original eligibility information provided by the client during the initial application process. The CHIP client is asked to review the eligibility information and then contact their eligibility staff to verify that the information is still correct or clarify any changes to the information. The only circumstance in which a client is required to provide additional documentation is if there has been a job change and, in that situation, the CHIP client is required to submit income verification.

Prior to simplifying the renewal process the CHIP clients were required to 'reapply' for coverage, including providing all required verification documents even if their eligibility criteria had not changed since their initial enrollment. The current renewal process requires just one phone call from the CHIP client, which is not only convenient for the client but also much less administratively burdensome to the eligibility staff.

8. Benefit structure N/C

9. Cost-sharing policies:

Utah modified the cost sharing requirements for eligible American Indian CHIP enrollees effective October 1, 1999. This modification was made in accordance with the October 6, 1999 policy letter from HCFA, addressed to State Health Officials, requiring the waiver of all cost sharing for this population. All of the Utah CHIP contracted health plans have systems in place to identify new American Indian enrollees in order that no cost sharing requirements are imposed on these CHIP enrollees for CHIP covered medical services.

Notification to the eight tribes in Utah, as well as each American Indian CHIP enrollee, and all participating CHIP providers in the state, was made immediately following the HCFA announcement. Utah CHIP and the Utah Indian Health Advisory Board have maintained a dialogue regarding the new policy in order that it continues to be successfully utilized.

10. Crowd-out policies N/C

11. Delivery system:

Altius Health Plans, one of the four contracted CHIP health plans, withdrew from the CHIP and Medicaid markets effective September 30, 2000. The Altius plan was offered to CHIP enrollees in the urban area (enrollees in Davis, Salt Lake, Weber, and Utah counties.) The withdrawal, announced July 2000, affected 2% of the CHIP enrollment at that time, approximately 175 enrollees.

Following the announcement by Altius, a notification letter was sent to all CHIP households enrolled with Altius informing them of the withdrawal and advising them that they would have 45 days to select one of the three remaining participating health plans. As well, each household was contacted by telephone (Hispanic households were contacted by Spanish speaking staff) to inform them of the change. As a result of the notification letter and telephone contacts, there were fewer than ten households who had not chosen a health plan by August 31, 2000. These households were assigned a health plan automatically by the computer enrollment system.

Altius' decision to leave the Medicaid market for financial reasons triggered their decision to leave the CHIP market due to their low enrollment. The risk selection with their relatively low enrollment, Altius

suggested, would have made their financial situation very tenuous.

12. Coordination with other programs (especially private insurance and Medicaid) N/C

13. Screen and enroll process N/C

14. Application N/C

15. Other N/C

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

   As of September 30, 2000, Utah CHIP had enrolled 18,421 eligible children. This number is an increase of 6,935 enrollees from the FFY 1999 CHIP enrollment, which ended with 11,486 eligible children enrolled.

   The enrollment numbers for CHIP are derived from the premium payments Utah CHIP is making to contracted CHIP health plans on behalf of verified CHIP enrollees.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

   Currently there is not a process available in Utah to generate this data.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

   The 2000 Utah legislature appropriated funding to continue the Utah Health Status Survey, a statewide health survey to be conducted in 2001. This survey will provide indicative data on state population, poverty levels, race, age, etc., as well as the number of children who are uninsured, insured privately, with CHIP, or on Medicaid. This same survey was conducted in 1996 and is the source for the current baseline estimate of CHIP eligible children in Utah.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   _X_ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State=s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State=s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State=s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State=s strategic objectives for your SCHIP program, as specified in your State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO INCREASING CHIP ENROLLMENT AND REDUCING THE NUMBER OF UNINSURED CHILDREN IN UTAH		
1.0 Reduce the percentage of Utah children, from birth to 19 years of age, who are uninsured.	1.1 By June 30, 1999, at least 10,000 previously uninsured low-income eligible children will be enrolled in Utah CHIP.	Data Sources: FY1998 through FY2000 CHIP enrollment data. Methodology: Number of eligible children enrolled in Utah CHIP by June 30, 1999 and number of eligible children enrolled in Utah CHIP as of September 30, 2000. Progress Summary: As of June 30, 1999, 10,014 previously uninsured, low-income eligible children were enrolled in Utah CHIP. As of September 30, 2000 this number had increased to 18,421.
1.0 Reduce the percentage of Utah children, from birth to 19 years of age, who are uninsured.	1.2 By June 30, 2000, the percentage of Medicaid eligible Utah children younger than 19 years of age who are enrolled in Medicaid will be increased from 80 to 90 percent.	**NC**
1.0 Reduce the percentage of Utah children, from birth to 19 years of age, who are	1.3 By June 30, 1999 the percentage of Utah children from birth to 19 years of age without health insurance will be	Data Sources: 1996 Utah Health Status Survey and fourth quarter FY 2000 CHIP enrollment data. Methodology: Utah CHIP enrollment for fourth quarter FY 2000, which reflects the total number of children enrolled in Utah CHIP.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
uninsured.	decreased from 8.5 percent to 6 percent.	Numerator: Number of Utah CHIP enrollees as of September 30, 2000. Denominator: Uninsured Utah children under the age of 19 years. Progress Summary: As of September 30, 2000, 18,421 eligible children were enrolled in Utah CHIP which decreases the percentage of uninsured children from 8.5% to the stated goal of 6%.
1.0 Reduce the percentage of Utah children, from birth to 19 years of age, who are uninsured.	1.4 By December 31, 1998, a coordinated statewide outreach program for the identification and enrollment of CHIP eligible children into the Utah CHIP will be established.	Progress Summary: Utah CHIP outreach efforts for the past year have shifted from a more broad based approach to concentrating on reaching those populations where there still seems to remain a large number of potential CHIP eligible children. CHIP has intensified its coordination with various programs and community organizations such as Baby Your Baby, Immunize by Two, the State Office of Education, WIC, Utah Nurses Association, and Primary Children's Hospital in order to streamline outreach efforts and reach as many CHIP eligible families as possible. CHIP increased the level of targeted outreach within Utah through greater communication with ethnic communities, direct mailings, re-focused media ads, and additional partnerships including March of Dimes, Head Start, Office of Recovery Services, and child care providers. Utah continues to utilize a statewide toll-free hotline telephone number to provide resource and referral information to interested individuals. The hotline can translate for callers in virtually any language needed. The hotline is also a main source for tracking response to CHIP outreach by recording how callers found the CHIP hotline number. CHIP advertising materials include television and radio ads, informational flyers, tri-fold brochures with the application attached inside, brochure holders, posters, business cards and pencils with the hotline number, and a five-minute informational video on the CHIP

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		program. The flyers, brochures, and video are also available in Spanish along with the CHIP application.
OBJECTIVES RELATED TO INCREASING ACCESS TO HEALTH CARE FOR CHILDREN ENROLLED IN UTAH CHIP		
2.0 Increase access to health care services for Utah children enrolled in Utah CHIP.	2.1 By June 30, 1999, at least 90 percent of children enrolled in Utah CHIP will have an identified usual source of care.	**NC**
2.0 Increase access to health care services for Utah children enrolled in Utah CHIP.	2.2 By June 30, 2000, there will be a decrease in the proportion of CHIP enrolled children who were unable to obtain needed medical care during the preceding year.	**NC**
2.0 Increase access to health care services for Utah children enrolled in Utah CHIP.	2.3 By June 30, 2000, at least 50 percent of five-year-old CHIP enrolled children will have received dental services prior to kindergarten entry.	**NC**
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
3.0 Ensure that children	3.1 By June 30, 2000, at	**NC**

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	least 50 percent of children who turned 15 months old during the preceding year and were continuously enrolled in Utah CHIP from 31 days of age, will have received at least four well-child visits with a primary care provider during the preceding year.	
3.0 Ensure that children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	3.2 By June 30, 2000, at least 60 percent of three, four, five, or six-year-old children who were continuously enrolled in Utah CHIP during the preceding year will have received at least one or more well-care visits with a primary care provider during the preceding year.	**NC**
3.0 Ensure that children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	3.3 By June 30, 2000, at least 85 percent of two year old children enrolled in Utah CHIP will have received all age-appropriate immunizations.	**NC**
3.0 Ensure that children	3.4 By June 30, 2000, at	**NC**

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	least 90 percent of 13 year old children enrolled in Utah CHIP will have received a second dose of MMR.	
3.0 Ensure that children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	3.5 By June 30, 2000, at least 50 percent of CHIP enrolled children eight years of age will have received protective sealants on at least one occlusal surface of a permanent molar.	**NC**
OBJECTIVES RELATED TO CHIP ENROLLED CHILDREN IN UTAH RECEIVING HIGH QUALITY HEALTH CARE SERVICES		
4.0 Ensure that CHIP enrolled children receive high quality health care services.	4.1 By June 30, 2000, the annual readmission rate for asthma hospitalizations among CHIP-enrolled children will have decreased compared to the rate during the previous year.	**NC**
4.0 Ensure that CHIP enrolled children receive high quality health care services.	4.2 By June 30, 1999, a set of quality care indicators will be selected and methods established for ongoing data collection and monitoring of these	**NC**

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	indicators.	
4.0 Ensure that CHIP enrolled children receive high quality health care services.	4.3 By June 30, 2000, at least 90 percent of CHIP enrollees surveyed will report overall satisfaction with their health care.	**NC**
OTHER OBJECTIVES		
5.0 Improve health status among children enrolled in Utah CHIP.	5.1 By June 30, 2000 no more than 20 percent of the Utah CHIP enrolled children ages six through eight years old will have untreated dental caries.	**NC**

1.4.1 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

See response to 1.6.

1.5 Discuss your State=s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The information and data required to provide measurements of the majority of strategic objectives and goals identified in sections two through five of the table in section 1.3 are not available for this report. The systems required to report and receive annual HEDIS and quarterly encounter data were recently completed by the contracted CHIP health plans and the Utah Department of Health. A CHIP enrollee CAHPS survey will be conducted during the next fiscal year in order to identify and assess the measures that HEDIS and encounter data do not specifically address, such as 2.0 (2.1 and 2.2) and 4.0 (4.3). Utah CHIP anticipates that the HEDIS, encounter, and CAHPS survey data will be available for inclusion in the FY 2001 CHIP Annual Report.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.

1. Utah CHIP Enrollment Survey Summary Results
2. Utah CHIP Hotline Found By Report
3. Utah CHIP Closure Report
4. 1999 Utah CHIP CAHPS Survey
5. Utah CHIP Contracted Required Health Plan Reports

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: *N/A FOR UTAH CHIP*

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

Number of adults_____
Number of children_____

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: *N/A FOR UTAH CHIP*

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Number of adults_____
Number of children_____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

Crowd-out for Utah CHIP is defined as the substitution of public coverage (CHIP) for private or employer sponsored health coverage.

2. How do you monitor and measure whether crowd-out is occurring?

Utah has established a three month waiting period for all CHIP applicants who have voluntarily disenrolled from private health coverage prior to applying for CHIP. At application CHIP applicants must identify if their child is currently insured and, if not, when the child was last covered and why that coverage was terminated.

As well, if health coverage is available to an applicant's dependents through an employer sponsored health plan, but the applicant has elected to not enroll their dependents in the plan, the cost of that coverage must exceed 5% of the applicant's income or the private coverage is considered affordable and the children are not eligible for CHIP.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Utah conducted a survey of new CHIP applicants (at the time of initial application) from December 15, 1999 through January 31, 2000, to determine previous insurance coverage. The survey indicated that CHIP applicants are, on average, uninsured for 13 months prior to making application with CHIP.

The Utah CHIP enrollment survey results (attached) identified three primary groups of CHIP applicants:

1. Medicaid was the most recent coverage, income eventually exceeded Medicaid limit, and the employer sponsored health coverage exceeded 5% (22% of respondents.)
2. Medicaid was the most recent coverage, income eventually exceeded Medicaid limit, and the employer did not offer health coverage (36% of respondents.)
3. Most recent coverage was employer sponsored which was terminated due to job loss, employer dropped coverage, or coverage became too costly (29% of respondents.)

Only 3% of the survey respondents had terminated employer sponsored coverage within three months of applying for CHIP. This indicates that Utah CHIP applicants are not substituting CHIP coverage for a private, or employer sponsored product.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

The enrollment survey suggests that parents are not disenrolling their children from private coverage and waiting for three months to apply for CHIP. As well, the CHIP benefit structure is similar to that of private and employer sponsored health insurance plans which decreases the incentive to move from private sector plans to CHIP.

2.4 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Due to the variety of ways an individual may learn of and make application for the CHIP program, the only evaluative measures Utah is currently able to use in regards to its outreach is actual enrollment data (by county and ethnicity) and the tallies from the CHIP hotline number. These tallies are collected and reported each month in the Found By Report (attached), which lists how callers found the CHIP hotline

number.

The activities Utah found to be most successful in reaching low-income, uninsured children during FFY 2000 were media campaigns, community partnerships, and direct mail to targeted households.

Of all the CHIP media campaigns in FFY 1999, TV ads brought in the most response to the hotline, while radio and bus board ads were considered unsuccessful. However, during FFY 2000, there has been a significant increase in the response to radio and bus boards. While TV still remained the highest overall ranked category on the hotline Found By report (20% of calls tallied), radio ads brought in the largest response during the two months they were played and averaged 10% of the total calls made each month.

Separate from media campaigns, health care providers, schools, and WIC made up a large percentage of the hotline calls received with 8%, 8% and 7% of the average total calls respectively. Each of these community partnerships facilitate greater outreach opportunities for the CHIP program and help to ensure that fewer children will fall between the cracks of available programs. School lunch coordination, presentations and booths at health fairs, etc. maintains an awareness of CHIP and continues to establish the program within the community of child health.

Near the end of FFY 2000, Utah designed and sent out a bi-lingual (English and Spanish) postcard with basic CHIP information along with the toll-free hotline number to call if interested. The postcard was targeted to families below a certain income level, with children, and living within an under-served population area (determined by estimated potential enrollment versus actual enrollment, geographical location, and health status). Among some of the communities included in this mailing were under-served urban populations, ethnic communities, and rural areas.

Using a direct mail piece put the CHIP hotline number right into the hands of families who may have forgotten to write it down when hearing an ad over the radio, or who did not want to go up to a table at a back to school night. In a breakdown of the "Other" category in the Found By report during September 2000, the bi-lingual postcard received over one-third of the "Other" calls. In fact, one caller even remarked that she kept meaning to write the number down but never did, and then one day she received the CHIP postcard in her mail so she made sure to call in that very same day.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Utah CHIP understands that within any community, especially one that may be identified as an ethnic, minority, migrant, or rural community, an appropriate message must be delivered in a culturally sensitive manner by a trusted individual with ties to that community. Utah has found that when centering outreach activities on this philosophy there is a much higher response from the targeted community. For example within the Hispanic community, CHIP presentations, media interviews and advertising were all done in Spanish. As well, CHIP outreach materials such as the tri-fold brochure, informational video, benefit

summary, and application are also available in Spanish.

In an effort to identify the needs of rural communities, the CHIP Administrator, along with the Utah Department of Health Medicaid Director, went on site visits to both the Northern and Southern regions of the State to meet with the eligibility staff. While visiting the Southern region, the CHIP Administrator took advantage of the opportunity to increase awareness of the CHIP program in that area by conducting local interviews with their newspaper and radio stations. Because statewide media campaigns can sometimes miss pockets of rural communities, this was an excellent way to communicate the availability of CHIP to rural families.

3. Which methods best reached which populations? How have you measured effectiveness?

Apart from the specific populations previously discussed in question 2, Utah has identified two general categories of CHIP eligible but not enrolled families, those who do not consider themselves eligible for a government program, and those that are within the community of public and private programs, but who have somehow been unable to connect with CHIP.

For those families who may not realize they would qualify for the CHIP program, Utah redesigned its TV and radio ads to target the eligibility guidelines that would most likely cause a family to disqualify themselves. Language was added to include "even families earning a reasonable income may qualify". In addition to purchased advertising, the CHIP Administrator appeared on local news stations for "Check Your Health" and back to school segments. Places such as health care providers, day care centers, and others were also targeted to reach working families who may not have any other contact with programs similar to CHIP.

For those that are within the community of public and private programs, but who have somehow been unable to connect with CHIP, Utah continued to focus on coordination with similar programs and organizations. Strong partnerships, streamlining outreach efforts, and taking an active role within the community is the only way to keep children from falling through the cracks of available programs. Being seen in the community and available to answer questions and/or offer clarification is an essential part of CHIP outreach.

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

Children on CHIP that are found to be eligible for Medicaid (and vice versa) are easily transferred to the other program through an electronic input from the same computer database management system and the same eligibility staff. In addition, two of the three CHIP health plans are also Medicaid health plans. Those children transferring between programs can maintain the same providers and facilities if they so choose.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

_X_ Follow-up by caseworkers/outreach workers
_X_ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population _____
___ Information campaigns
_X_ Simplification of re-enrollment process, please describe:

Utah redesigned its CHIP renewal forms and established new renewal procedures in order to simplify and streamline the renewal process for the CHIP clients and the eligibility staff. These changes were implemented July 2000. The new form, sent to CHIP clients at the end of the twelve month continuous enrollment period, includes the original eligibility information provided by the client during the initial application process. The CHIP client is asked to review the eligibility information and then contact their eligibility staff to verify that the information is still correct or clarify any changes to the information. The only circumstance in which a client is required to provide additional documentation is if there has been a job change and, in that situation, the CHIP client is required to submit income verification.

Prior to simplifying the renewal process the CHIP clients were required to 'reapply' for coverage, including providing all required verification documents even if their eligibility criteria had not changed since their initial enrollment. The current renewal process requires just one phone call from the CHIP client, which is not only convenient for the client but also much less administratively burdensome to the eligibility staff.

___ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____
_X_ Other, please explain: Utah CHIP Closure Report

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Utah CHIP does not collect nor measure Medicaid data.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

From the outset, Utah CHIP was designed to resemble a commercial health plan and, as such, twelve-month eligibility standard was implemented in order to mirror that of an employer sponsored health plan, with renewal every twelve months. This has provided the enrollees with the security of knowing that their initial enrollment, and subsequent renewals are virtually guaranteed for twelve continuous months. This continuous eligibility benefit, in Utah's opinion,

and due to the fact that the number one reason CHIP enrollees do not renew their coverage is because

they have obtained employer sponsored health coverage either previously not available or not affordable, is the main reason Utah kids are staying enrolled on CHIP.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Utah CHIP conducted an enrollee closure survey in October 1999. Each of the households whose CHIP twelve month continuous coverage was terminated in August, 1999, and who hadn't subsequently renewed their CHIP coverage within sixty days, were contacted to inquire why they hadn't re-enrolled or renewed their coverage with CHIP. At the time this survey was conducted Utah CHIP was using the original method of renewal, that is, enrollees were required to submit all verification documentation to the eligibility staff in order to determine eligibility for the next twelve month period.

The results of this survey (attached at the end of this report) indicate that the largest group of respondents, approximately 40%, had obtained employer-sponsored coverage and, therefore, did not complete the renewal process for CHIP. 26% of the respondents said they would be reapplying for CHIP and that the reason they hadn't completed the review was because they either hadn't enough time, forgot, or thought they were over the income limits for eligibility.

Utah CHIP is currently conducting this survey on a monthly basis so that children who are eligible remain enrolled. Households who do not complete the new renewal process are contacted by an eligibility staff person (who also speaks Spanish) to determine the reason the review was incomplete. While CHIP anticipates that the majority of the households will have obtained other coverage, either private or employer sponsored, if the family is in fact still eligible for the program, eligibility person is then able to re-enroll or renew the children's coverage over the phone at that time.

Utah CHIP will report on the results of this effort in the FY 2001 Annual Report.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Utah uses a CHIP only application. If the financial information on that application is within Medicaid guidelines, the eligibility staff has the CHIP applicant complete an addendum providing enough information to determine if, in fact, the applicant is eligible for Medicaid. This can be accomplished efficiently because Utah has the same eligibility staff for Medicaid and CHIP. The applicants like this short, non-bureaucratic CHIP application. If Utah were to have a joint CHIP/Medicaid application (with all the required Medicaid eligibility information) the CHIP application would be about 3-4 times longer; and there is concern that many potential applicants would not complete the application because of its size. A good case can likely be made that separate applications actually lead to more children being insured. The addendum acts as the bridge to Medicaid from CHIP,

without having to burden the applicant with the additional Medicaid requirements.

2. Explain how children are transferred between Medicaid and SCHIP when a child=s eligibility status changes.

Children on CHIP that are found to be eligible for Medicaid (and vice versa) are easily transferred to the other program through an electronic input from the same computer database management system and the same eligibility staff.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Two of the three CHIP health plans are also Medicaid health plans. Those children transferring between programs can maintain the same providers and facilities if they so choose.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Utah CHIP does not collect premiums from its enrollees or impose enrollment fees on its applicants.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

To date, Utah CHIP has not collected this information, however, the effects of cost-sharing requirements on the utilization of CHIP medical services received by CHIP enrollees will be collected and evaluated by the CHIP CAHPS survey scheduled to be conducted during FY 2001.

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

The most recent information available that specifically addreses and measures the quality of care received by CHIP enrollees is contained in the 1999 CHIP CAHPS survey (attached at the end of this report.)

The results of this survey were very encouraging and include specifics such as:

- Satisfaction of Utah CHIP health care: On a scale of one (1) to ten (10), with ten being the best, 91.7% of survey respondents rated their satisfaction of Utah CHIP health care between seven (7) and 10. 45.6% of survey respondents rated their Utah CHIP health care as the best health care possible.

- Opinion of the time child spends during appointments with medical professionals: Using a scale of percentages, with 100% being the best, 92.4% of the respondents indicated that doctors or other health providers usually (21.9%) or always (70.5%) spent enough time with their child.

- Opinion of child's overall health: Using a percentage scale, 78.4% of the respondents indicated that their child's health was very good (30.4%) or excellent (48%.)

- Satisfaction of selected health plan: On a scale of 1 to 10, with 10 being the best health plan possible, 88.4% of the respondents rated their satisfaction between 8 and 10. 48.7% of survey respondents rated their Utah CHIP health plan as the best possible.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

See response to question 2.8.3

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The systems required to report and receive annual HEDIS and quarterly encounter data were recently completed by the contracted CHIP health plans and the Utah Department of Health. CHIP will be collecting annual HEDIS data (reported by the contracted health plans on September 1, for the previous calendar year) beginning FY 2001. Encounter data will also be collected on a quarterly basis. A table listing all of the reports required from the contracted CHIP health plans has been attached at the end of this report.

In addition to the required health plan reports, a CHIP enrollee CAHPS survey will be conducted during the next fiscal year in order to identify and assess the measures that the HEDIS and encounter data do not specifically address. Utah anticipates that the HEDIS, encounter, and CAHPS survey data will be available for inclusion in the FY 2001 CHIP Annual Report.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility:

Utah uses a CHIP only, five question, application to determine eligibility. The applicants like this short, non-bureaucratic CHIP application and, in fact, many eligibility staff have commented that individuals applying for Medicaid often inquire about how they can get the 'easy' application in reference to the CHIP application.

If the financial information provided on the CHIP application is within Medicaid guidelines, the eligibility staff has the CHIP applicant complete an addendum providing enough information to determine if, in fact, the applicant is eligible for Medicaid. This can be accomplished efficiently because Utah has the same eligibility staff for Medicaid and CHIP.

If Utah were to have a joint CHIP/Medicaid application (with all the required Medicaid eligibility information) the CHIP application would be about 3-4 times longer; and there is concern that many potential applicants would not complete the application because of its size. A good case can likely be made that separate applications actually lead to more children being insured. The addendum acts as the bridge to Medicaid from CHIP, without having to burden the CHIP applicant with the additional Medicaid requirements.

2. Outreach:

During FFY 2000, Utah produced a 5-minute informational video, which explains the program in detail. This video is helpful in explaining the program to teachers, physicians, office staff, and other employees that have frequent contact with potentially CHIP eligible children and their parents throughout the State. The video can also be shown to the public at many locations such as doctor offices, clinics, and emergency rooms. It is available in English and Spanish, as well as a looped English version that will play continually for 90 minutes.

After the production of this video, outreach packets were sent to several organizations consisting of, among others, schools, ethnic groups, health care providers, and community programs. Packets included a supply of the new CHIP brochures with the application attached inside, a brochure holder, and postage paid reply card to request additional CHIP materials and/or a visit from a CHIP representative. The mailing initiated several calls and responses by mail for CHIP presentations and

materials, increasing the level of resources available in the community.

3. Enrollment:

Enrollment projections were being met or exceeded during FFY 2000. There were, however, concerns among certain ethnic communities, especially the Hispanic community, that CHIP was not identifiable in their population as a source of health insurance for their children. The CHIP administrator coordinated with a Hispanic advocate to provide a summary of CHIP, in Spanish, at Spanish-speaking Catholic masses during their announcement portion of the mass. The priest would introduce the administrator and say a few positive words about CHIP. The administrator and Hispanic advocate would pass CHIP applications and flyers out to the congregation as they left the mass. The reception among the congregation was very encouraging. This has taken place in approximately 5 masses with more scheduled.

At the end of FFY 1999, a new, one-page CHIP application was developed because of concerns that potential applicants were daunted by the lengthy Medicaid application. Although this newapplication is separate from Medicaid, the CHIP/Medicaid enrollment staff simply use an addendum to the separate CHIP application if a complete Medicaid application is required by virtue of the applicant's income. This change also encouraged Medicaid to streamline their Medicaid application. This shortened application remains a significant enhancement to the CHIP (and Medicaid) program.

4. Retention/disenrollment:

Much concern and attention was focused on this issue during FFY 2000. Informal surveys were taken and reports were generated to identify why enrollees disenroll in CHIP. Again, based on these informal survey methods, the number one reason for disenrollment is that enrollees get coverage in the private sector. However, there is still a significant number of enrollees that do not return renewal forms or respond to phone calls. Many of these enrollees may have found other insurance and simply did not return the renewal forms.

Early in FFY 2000, the renewal process in CHIP was the same as the initial enrollment process; in other words, enrollees were required to send income verification documents to CHIP offices and insurance information was re-verified. These steps seemed to be unnecessarily obstructing the renewal process. A new process was programed and introduced where enrollees would receive a pre-printed form including all the household information necessary for CHIP eligiblity. The enrollee was instructed to simply call a local CHIP office and tell the CHIP staff if this information is still correct. If changes occurred during the year, modifications are accepted without documented verification. Only in the case of a job change will new verification documents be required at renewal.

The Disenrollment SWAT Team facilitated by the National Association of State Health Policy (NASHP), and funded by the Packard Foundation, will be a great asset to determine how successful this new process has been. The SWAT Team will also survey disenrollees to accurately assess why enrollees disenroll.

5. Benefit structure N/A

6. Cost-sharing:

Utah CHIP includes cost sharing requirements in the form of co-payments and small co-insurance requirements (for example, Plan B enrollees are required to pay 10% of inpatient and outpatient hospital costs, up to the out of pocket annual maximum of $800.00.) CHIP does not require enrollees to pay monthly premiums, nor are applicants required to pay an enrollment fee. By requiring small co-payments, between $2 to $10, it allows the enrollees to participate in their children's health coverage and the feedback from the enrollees has supported this philosophy. Utah CHIP office has not received any complaints from enrollees or applicants about copayment levels, in fact, the only comments received have been supportive of these copayments.

By requiring co-payments at the time medical services are received, instead of monthly premiums regardless if medical services are utilized, enrollees are paying on an 'as-needed' basis; children are enrolled, insured, and receiving preventive care. Requiring enrollees to pay monthly premiums, it was decided during plan design, would provide potential applicants the hardship of paying for a product they may not 'need' at the time, and would provide enough incentive for the parent to postpone application and/or enrollment until their child required medical care, usually received at an emergency or urgent care center.

7. Delivery systems N/A

8. Coordination with other programs:

Collaboration between public and private organizations has always been an important element to the growth and overall success of the Utah CHIP program. In an effort to strengthen community partnerships even further, Utah CHIP established an Outreach Subcommittee in May 2000, to assist CHIP in reaching the many organizations, professionals, and families throughout the State. The individuals who serve on this subcommittee represent pediatricians, physician office staff, WIC, Head Start, community health centers, ethnic populations, March of Dimes, State Office of Education, nurses, hospitals, children with special health care needs, consumers, and many other groups.

The subcommittee is tasked with identifying ways that Utah CHIP can best outreach to families and community groups with whom they have individual expertise and involvement. The initial response has been very encouraging, with several new ideas/ campaigns being brought to the table at each meeting. During these meetings subcommittee members not only discuss how to implement an outreach approach, but will also often take the lead on those strategies that coordinate with their area of expertise.

In addition to the CHIP Outreach Subcommittee, Utah will persist in its efforts to seek out partnerships with those organizations that have frequent contact with CHIP-eligible children, such as the Migrant Coordinating Committee (within the State Office of Education), the PTA Health Commission, and several others.

9. Crowd-out:

Utah has established a three month waiting period for all CHIP applicants who have voluntarily disenrolled from private health coverage prior to applying for CHIP. At application CHIP applicants must identify if their child is currently insured and, if not, when the child was last covered and why that coverage was terminated. As well, if health coverage is available to an applicant's dependents through an employer sponsored health plan, the cost of that coverage must exceed 5% of the applicant's income or the private coverage is considered affordable and the children are not eligible for CHIP. As well, if health coverage is available to an applicant's

Based on the results of Utah CHIP Closures Report, only 3% of the respondents/CHIP applicants indicated that they had terminated employer sponsored coverage within three months of applying for CHIP but do not indicate that they terminated employer-sponsored coverage in order to replace that coverage with CHIP.

The results of the closure report indicate that Utah CHIP applicants are not substituting CHIP coverage for a private, or employer sponsored product.

10. Other N/A

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care	$14,873,738	$19,585,000	$24,121,000
per member/per month rate X # of eligibles			
Fee for Service			
Total Benefit Costs	$14,873,738	$19,585,000	$24,121,000
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	$14,873,738	$19,585,000	$24,121,000
Administration Costs			
Personnel	$117,491	$215,593	$224,216
General administration	$115,675	$177,907	$177,907
Contractors/Brokers (e.g., enrollment contractors)	$477,062	$900,000	$1,100,000
Claims Processing			
Outreach/marketing costs	$318,575	$250,000	$250,000
Other	$131,372	$140,000	$140,000
Total Administration Costs	$1,160,181	$1,683,500	$1,892,123
10% Administrative Cost Ceiling	$1,636,111	$2,154,350	$2,653,310
Federal Share (multiplied by enhanced FMAP rate)	$12,841,566	$17,016,927	$20,550,367
State Share	$3,793,353	$4,251,573	$5,462,756
TOTAL PROGRAM COSTS	**$16,033,919**	**$21,268,500**	**$26,013,123**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

N/A FOR UTAH CHIP

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

_X_ State appropriations
____ County/local funds
____ Employer contributions
____ Foundation grants
____ Private donations (such as United Way, sponsorship)
____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures?

No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name		Utah Children's Health Insurance Program (CHIP)
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	__X__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____
Average length of stay on program	Specify months _____	Specify months __11.21__
Has joint application for Medicaid and SCHIP	_____No _____Yes	__X__No _____Yes
Has a mail-in application	_____No _____Yes	_____No __X__Yes
Can apply for program over phone	_____No _____Yes	_____No __X__Yes - But is required to sign final application
Can apply for program over internet	_____No _____Yes	__X__No _____Yes
Requires face-to-face interview during initial application	_____No _____Yes	__X__No _____Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months _____ What exemptions do you provide?	_____No __X__Yes, specify number of months __3_____ What exemptions do you provide? *Three-month waiting period required only if coverage is voluntarily terminated prior to making application.*
Provides period of continuous coverage <u>regardless of income changes</u>	_____No _____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	_____No __X__Yes, specify number of months ___12_____ Explain circumstances when a child would lose eligibility during the time period - *If children are enrolled on private or employer sponsored coverage during the 12-month period.*
Imposes premiums or enrollment fees	_____No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	__X__No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	_____No _____Yes	_____No __X__Yes
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No __X___ Yes, we send out form to family with their information and: <u>X</u>* ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed - **Confirmation from family can be done by telephone, mail, or in person.*

5.2 Please explain how the redetermination process differs from the initial application process.

The initial application process requires that each applicant submit documentation to verify age and citizenship of each child as well as income verification. This information is used to determine initial eligibility and eligible enrollees are then enrolled for twelve months of continuous eligibility.

Effective July, 2000, Utah implemented new CHIP renewal forms and procedures in order to simplify and streamline the renewal process for the CHIP clients and the eligibility staff. The new form, sent to CHIP clients at the end of the twelve month continuous enrollment period, includes the original eligibility information provided by the client during the initial application process. The CHIP client is asked to review the eligibility information and then contact their eligibility staff to verify that the information is still correct or clarify any changes to the information. The only circumstance in which a client is required to provide additional documentation during their renewal review is if there ahs been a job change and, in that situation, the CHIP client is required to submit income and insurance information.

Prior to simplifying the renewal process, the CHIP clients were required to 'reapply' for coverage, including providing all required verification documents even if their eligibility criteria had not changed since their initial enrollment. The current renewal process requires just one phone call from the CHIP client, which is not only convenient for the client but also much less administratively burdensome to the eligibility staff.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child=s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	133 % of FPL for children under age 6
	100 % of FPL for children aged 0 - 6
	____% of FPL for children aged _____
Medicaid SCHIP Expansion	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____
State-Designed SCHIP Program	200 % of FPL for children aged 0 through 18
	____% of FPL for children aged _____
	____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes __X__ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$ 0.00	$	$ 0.00
Self-employment expenses	$ 0.00	$	$ 0.00
Alimony payments Received	$ 0.00	$	$ 0.00
Paid	$ 0.00	$	$ 0.00
Child support payments Received	$ Allow deduction of first $50.00	$	$ 0.00
Paid	$ 0.00	$	$ 0.00
Child care expenses **Allow deduction of $200.00 per month per child age 0 to 2 1/2 years, $175.00 per month per child above age 2 1/2 if recipient is working full time. **Allow deduction of $160.00 per month per child age 0 to 2 1/2 years, $140.00 per month per child above age 2 1/2 if recipient is working part time.	$ **Age Based	$	$ 0.00
Medical care expenses	$	$	$ 0.00
Gifts ***Cash gifts up to $30.00 per household member per quarter.	$ ***	$	$ 0.00

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Other types of disregards/deductions (specify)	$ None	$	$ None

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups	____No	_X_ Yes, specify countable or allowable level of asset test_**** ___
Medicaid SCHIP Expansion program	____No	____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program	_X_ No	____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____	____No	____Yes, specify countable or allowable level of asset test_____

****Children 6 years to 18 years: $3000 countable asset limit allowed for households of two (2), $25 per additional person.

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes _X_ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage.

Utah's separate, non-Medicaid CHIP program will not be able to change Medicaid policy that would pass HCFA's new 1115 Waiver Guidelines for CHIP in order to provide family coverage.

2. Employer sponsored insurance buy-in.

There is a desire to examine this policy change, but the restrictive nature of the regulations make it difficult, if not impossible, to implement.

3. 1115 Waiver.

Utah would like to submit an 1115 Waiver but realizes that HCFA's regulatory requirement forcing CHIP programs to change Medicaid policy and State legislative rulings has excluded Utah from an ability to expand coverage or benefits to Utahns. Utah would certainly encourage HCFA to rethink this self-imposed requirement.

4. Eligibility.

Changes to Utah's enrollment application were discussed in Section 3.3.

5. Outreach.

Utah continues to look for avenues to expand outreach to Utahns who remain uninsured and eligible for CHIP. Utah is in the process of hiring a bi-lingual employee to serve as a liaison to ethnic communities throughout the State. Utah is also identifying "cultural messengers" for each ethnic community to serve as a focal point in CHIP information dissemination and gathering to their respective communities.

School lunch administrators and the school lunch program are also a prime target of further outreach in the State. School Nurses, Child Care Licensors and Providers are also identified to provide information to potential CHIP families.

Utah's CHIP is developing a semi-annual newsletter to be distributed to all enrollees, past enrollees, and community organizations. The newsletter will include: progress/enrollment data; information for enrollees, such as the need to renew every 12 months, open enrollment, and who to contact when they have questions; as well as highlighting a CHIP family and community based partners.

Utah CHIP will have a new web site shortly. The address will be www.utahchip.org. The site will contain, among other things, a downloadable application, eligibility and member services information, success stories, outreach materials available to community organizations, and links to our HMO providers as well as numerous community partners.

Utah CHIP is also designing a 4" x 6" Referral Card which will be used by both public and private organizations, such as Head Start, WIC, and other community based groups, in referring potentially eligible families to the CHIP program. The referral card will give basic program information and eligibility criteria, including income limits, as well as a place for their name and address. Once the self addressed, postage paid card is filled out and sent in, the interested family will receive a CHIP application and program information.

6. Enrollment/redetermination process.

Changes to Utah's renewal process were discussed in Section 3.4.

Utah is allowing enrollees a four-day grace period from date of application where CHIP will pay for services. Currently, CHIP pays for services from the date of application. In order to allow for traumatic events where the parents may not be reasonably expected to be able to complete an application, Utah will allow services to be paid for four-days prior to the date of application in these situations.

7. Contracting.

No changes anticipated.

ATTACHMENTS

1. Utah CHIP Enrollment Survey Results
2. Utah CHIP Hotline Found By Report
3. Utah CHIP Closure Report
4. 1999 Utah CHIP CAHPS Survey
5. Utah CHIP Contracted Required Health Plan Reports